Compass Health Network

Delegation of Another Person to Consent for Treatment of a Minor

Patient Name: ____ Date of Birth:__________________

***Fill out this form if the patient is a minor and you (the guardian) would like other adults to be able to bring the child to his/her appointments. ***

I, ____ (parent/legal guardian), cannot accompany my child,

____ (child's name) to Compass Health Network. Therefore, I give permission to the following adult(s) to bring my child to his/her appointments:

*Person bringing child must be 18 years or older. *

Name: ______________________________ Relationship: ________________________________

Name: ______________________________ Relationship: ________________________________

Name: ______________________________ Relationship: ________________________________

______(initials) I give permission for this person to seek treatment for my child including any type of medical care, diagnostic test, mental health care, immunizations, procedure, and the administration of local anesthesia determined by a physician, nurse practitioner, or dentist, to be necessary for the welfare of my child, and provide consent **without having to contact me**.

This form will remain in effect until revoked by me. Please notify the office at any time if you would like to revoke this permission.

This form is **ONLY VALID** during the following timeframe:

Effective date: _________________________ Expiration date: _________________________

____

Signature of Parent/Guardian Relationship Date

____

Signature of Witness Date